UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

IN RE: VALSARTAN PRODUCTS LIABILITY LITIGATION **This Document Relates to:**	MDL No. 2875 Honorable Robert B. Kugler, District Judge Honorable Joel Schneider, Magistrate Judge

PLAINTIFF'S FACT SHEET FOR INDIVIDUAL PERSONAL INJURY CASES

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Valsartan products by a plaintiff, claiming personal injuries due to use of Valsartan. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. When attaching additional sheets, clearly label to what question your answer pertains to. Please do not leave any blank spaces; if a question does not apply, respond "N/A".

In filling out this form, please use the following definitions: (1) the terms "Plaintiff," "you," and "your," refer to the individual referenced in the caption of this Plaintiff's Fact Sheet, (2) **"health care provider"** means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, provider of telemedical services, whether real-time telemedicine, remote patient monitoring, or store-and-forward service, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (3) **"document"** means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form; (4) "Valsartan product" means any Valsartan containing product, including but not limited to Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCZT); (5) "Complaint" means the operative complaint filed in your case, whether an original or amended or subsequent complaint.

Information provided by plaintiff will only be used for purposes related to this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court cases, the governing rules of the state in which the case is pending) and Case Management Order No. 7 ("CMO-7").

I. CORE CASE INFORMATION

A. Please provide the following information for the civil action which you filed:

Caption:	
Court and Docket No. (and MDL Docket No. if different):	Court: Docket No.:
Plaintiff's Attorney, Law Firm, Address, Phone Number, and Email Address:	Attorney: Michael S. Mehrmann Law Firm: Mehrmann Law Offices Address: 29 Main Street Kingston MA 02364 Phone Number: 781-585-3911 Email Address: michael@mehrmannlaw.com
Date Lawsuit Filed:	
Jurisdiction where suit would have been filed (if direct filed into MDL):	

B. Please provide the following information for the Plaintiff/decedent on whose behalf this action was filed, and for any spouse of the plaintiff:

First Name:	NANCY	Last Name:	LALONDE
Address:	43 Oak Street	City:	Duxbury
State:	MA	Zip Code:	02332
Date of Birth:	Jul 21 1949	Gender:	female
Social Security Number: (including past SSNs, if applicable):	058422557	All other names by which Plaintiff has been known (including, but not limited to maiden, prior married, nicknames, and aliases):	Nancy Ellen Hobbs

Spouse First Name:	Kevin	Spouse Last Name:	Lalonde
Spouse Address:	43 Oak Street	Spouse City:	Duxbury
Spouse State:	MA	Spouse Zip Code:	02332
Spouse Date of Birth:	Jun 12 1949	Spouse Gender:	Male
Spouse Social Security Number: (including past SSNs, if applicable):	055-40-5705	All other names by which Spouse has been known (including, but not limited to maiden, prior married, nicknames, and aliases):	None

Primary Language if other than English: _____

C. Please provide the following information regarding usage of Valsartan products.

I HAVE IN MY POSSESSION RECORDS DEMONSTRATING USE OF VALSARTAN, AMLODIPINE/ VALSARTAN, VALSARTAN/HYDROCHLOROTHIAZIDE (HCTZ), AND/OR AMLODIPINE/VALSARTAN/ HYDROCHLOROTHIAZIDE (HCTZ): Yes☑ No ☐

IF YES, YOU MUST ATTACH COPIES OF PRESCRIPTION AND/OR PHARMACY RECORDS DEMONSTRATING PRODUCT USE. ALSO ATTACH ANY COPIES OR PHOTOGRAPHS OF PRESCRIPTION BOTTLES OR LABELING IN YOUR POSSESSION.

Identify Product(s) and set forth for each:

Select Product:	Valsartan	Valsartan/Hydrochlorothiazide	Amlodipine/Valsartan
Dosage:	25 mg tabs	25 mg tabs	25 mg
NDC Code (if known):	65862-0201-99	00603-3856-32	1729-0183-17
Lot Number (if known):			
Batch Number (if known):			
API Manufacturer (if known):			

Labeler/Distributor (if known):			
Repackager (if known):			
Start Date:	May 25 2016	Mar 31 2016	Jun 29 2016
End Date:	May 28 2019	Jul 31 2016	Jul 31 2016
Reason for Prescription:	High Blood Pressure	High Blood Pressure	
Name and Address of Prescribing Physician:	Dimitar Dimitrov, MD 286 Kingstown Way Duxbury MA 02332	Dimitar Dimitrov, MD 286 Kingstown Way Duxbury MA 02332	Dimitar Dimitrov, MD 286 Kingstown Way Duxbury MA 02332
Name and Address of Pharmacy(ies):	Stop & Shop Summer Street Kingston MA02364	Stop & Shop Summer Street Kingston MA02364	Stop & Shop Summer Street Kingston MA02364
Check if you have records demonstrating Product ID	☑	☑	☑

Select Product:	Amlodipine/Valsartan		
Dosage:	5 mg		
NDC Code (if known):	67877-0198-05		
Lot Number (if known):			
Batch Number (if known):			
API Manufacturer (if known):			

Labeler/Distributor (if known):			
Repackager (if known):			
Start Date:	Aug 10 2019		
End Date:			
Reason for Prescription:	Hypertension		
Name and Address of Prescribing Physician:	Daniel Oates, MD 286 Kingstown Way Duxbury MA 02332		
Name and Address of Pharmacy(ies):	Stop & Shop Summer Street Kingston MA02364		
Check if you have records demonstrating Product ID	☐	☐	☐

Select Product:			
Dosage:			
NDC Code (if known):			
Lot Number (if known):			
Batch Number (if known):			
API Manufacturer (if known):			

Labeler/Distributor (if known):			
Repackager (if known):			
Start Date:			
End Date:			
Reason for Prescription:			
Name and Address of Prescribing Physician:			
Name and Address of Pharmacy(ies):			
Check if you have records demonstrating Product ID	☐	☐	☐

Select Product:			
Dosage:			
NDC Code (if known):			
Lot Number (if known):			
Batch Number (if known):			
API Manufacturer (if known):			

Labeler/Distributor (if known):			
Repackager (if known):			
Start Date:			
End Date:			
Reason for Prescription:			
Name and Address of Prescribing Physician:			
Name and Address of Pharmacy(ies):			
Check if you have records demonstrating Product ID	☐	☐	☐

IF YOU DID NOT CHECK THE BOX INDICATING YOU HAVE RECORDS DEMONSTRATING PRODUCT ID FOR ANY OF THE DRUGS LISTED ABOVE, YOU MUST CERTIFY AS FOLLOWS (check all that apply):

I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Valsartan product(s) used in my treatment:

If certifying the above, please describe your reasonable, good faith efforts:

I certify that I have requested records from:

Pharmacy, ☑

Prescribing physician, ☑ and/or

Health insurance provider; ☐

and the manufacturer either remains unknown at this time ☐

or I am awaiting the records. ☐

D. Please provide the following information regarding your alleged injury.

YOU MUST ATTACH MEDICAL RECORDS IN YOUR POSSESSION DEMONSTRATING ALLEGED INJURY

Set forth for each cancer you claim as a result of taking Valsartan:

Date of Original Diagnosis of Cancer	Aug 15 2019		
Select Cancer Type:	Colon		
Specify Other Cancer (if Applicable):			
Highest Stage Diagnosed:	2		
Metastasis of Cancer to other Organs? (Yes/No)	No		
Remission Date (if applicable):	☑ N/A	☐ N/A	☐ N/A
Description of Treatment	Resection of approximately twelve inches of small intestines and ascending colon		

E. If you are completing this questionnaire in a representative capacity *(e.g.,* on behalf of the estate of a deceased person), please complete the following:

Name:	
Address:	
Capacity in which you are representing the individual:	
If you were appointed as a representative by a court state the State, Court and Case Number and attach supporting documentation:	State: Court: Case Number:
Relationship to the Represented Person:	
State the date and place of death of the decedent (if applicable):	

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person whose medical treatment involved the use of Valsartan, Amlodipine/ Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ). Those questions using the term "You" refer to the person whose treatment involved the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ). If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. PERSONAL INFORMATION

A. Background Information

1. Medicare Health Insurance Claim Number (if applicable):

5DW8-Y29-YM45

2. Name: Nancy Lalonde

Maiden or other names you have used or by which you have been known:

Current Address and date when you began living at this address:

Address: 43 Oak Streeet Duxbury MA 02332

Date: Sep 1 2020

3. Identify each address at which you have resided during the last ten (10) years and the approximate dates during which you lived at each address (most recent first):

Address			Approximate Dates you lived at each address			
2 Briarwood Court Kingston	MA	02364	Dec 1 2015 Aug ?? 2020			to ☐ Present
Evergreen Street Kingston	MA	02364	?? ?? 2011 Nov 30 2015			to ☐ Present
15 Landing Road Kingston	MA	02364	?? ?? 1987 ?? ?? 2011			to ☐ Present
						to ☐ Present
						to ☐ Present
						to ☐ Present
						to ☐ Present
						to ☐ Present

4. Do you have a driver's license? Yes ☑ No ☐

If yes, state of issuance: MA ; DL Number: S15751536

B. Family Information

1. Have you ever been married? Yes ☑ No ☐
If yes, for each spouse, state the spouse's name, the date of marriage, the date the marriage ended, the nature of termination *(e.g.,* death, divorce, etc.), and that spouse's present address:

Spouse's Name	Date of Marriage	Date Marriage Ended	Nature of Termination	Spouse's Present Address
Kevin Lalonde	?? ?? 1971	☑ N/A		43 Oak Street Duxbury MA 02332
		☐ N/A		
		☐ N/A		
		☐ N/A		

2. Has your spouse filed a loss of consortium or other claim in this lawsuit?
Yes ☑ No ☐

3. If you have children, please identify each child's name, address and date of birth:

Child's Name	Address	Date of Birth
Megan Roderick	5 Seaview Road Sagamore MA 02562	Apr 3 1974
Jonathan Lalonde	43 Oak Street Duxbury MA 02332	Sep 11 1976

Child's Name	Address	Date of Birth

C. Educational History

Provide the following information regarding Plaintiff's educational background, beginning with high school. Identify each high school and including, but not limited to trade or, vocational schools, colleges, universities or other post- secondary educational institutions you attended, the institution's address, the dates of attendance, and the diplomas or degrees awarded:

Name of School	Address	Dates of Attendance	Diploma/Degree Awarded
The Convent School	Court Street Syracuse NY	Sep 1 1963 to ?? ?? 1967 ☐ Present	High School
Central City Business Institute	 Syracuse NY	?? ?? 1968 to 1970 ☐ Present	Business School Certificate
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	

D. Employment History

Whether or not you are making a lost wage claim, please respond to all questions in this section except as noted:

1. Are you currently employed? Yes ☐ No ☑

If yes, identify your current employer with name, address and telephone number and your title/position there:

Employer: _____

Address:

_____

Telephone Number: _____

Title/Position: _____

2. Please identify each of your employers over the past ten (10) years, including the dates of such employment and positions held (most recent first). If you were self-employed during the relevant time, please also include the relevant information (you only need to supply rate of pay or salary if you are making a lost wage claim in this lawsuit):

Employer and Type of Business	Address	Title or Position	Dates of Employment	Pay Rate/ Salary
Self-Employed	42 Tremont Street Duxbury MA 02332	Administrator	?? ?? 1985 to ?? ?? 2019 ☐ Present	Varied
			to ☐ Present	
			to ☐ Present	

Employer and Type of Business	Address	Title or Position	Dates of Employment	Pay Rate/ Salary
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	

3. Have you been out of work for more than thirty (30) consecutive days for reasons related to your health in the past ten (10) years? Yes ☐ No ☐

If yes, please state the dates, employer, and the health condition causing your absence from work:

Name of Employer	Dates	Health Condition
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	

4. To your knowledge have you had regular exposure to (select all that apply):

Exposure to:	Type/Frequency	Dates of Exposure
Cadmium (i.e., battery production, cadmium mining)	Occupational ☐ Other ☐	
Coal industry	Occupational ☐ Other ☐	
Diet includes red and/or processed meats	Approximately _____ meals per week	
Diet includes smoked foods, salted meat and fish, and/or pickled vegetables	Approximately _____ meals per week	
Metal industry (i.e., steel facilities, smelting)	Occupational ☐ Other ☐	
Organic solvents (i.e., trichloroethylene, perchloroethylene, methylene chloride)	Occupational ☐ Other ☐	
Pesticides (includes herbicides)	Occupational ☐ Other ☐	
Radiation (i.e., therapeutic radiation, thorotrast radiography, nuclear industry work)	Occupational ☐ Other ☐	
Rubber industry	Occupational ☐ Other ☐	
Vinyl chloride	Occupational ☐ Other ☐	

E. Military Service

Have you ever served in any branch of the military? Yes ☐ No ☑

1. *If yes,* branch and dates of service:

Branch	Dates of Service
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present

If yes, highest rank: _____

If yes, military occupational specialty ("MOS"):

_____

If yes, were you discharged for any reason relating to your health (whether physical, psychiatric, or other health condition)? Yes ☐ No ☐

If yes, state the health condition:

2. Have you ever been rejected from military service for any reason relating to your health (whether physical, psychiatric, or other health condition)?

Yes ☐ No ☑

If yes, state the health condition:

F. Worker's Compensation and Disability Claims: Have you ever filed for worker's compensation related to a claim of occupational exposure to a carcinogenic substance, or for social security and/or state or federal disability benefits for any reason?

Yes ☐ No ☑

If yes, please then as to each application, separately state the following:

Year claim was filed: _____

Where claim was filed: _____

Claim/docket number, if applicable: _____

To what government agency or company did you submit your application:

_____

Nature of claimed injury: _____

Period of disability: _____

Amount awarded: _____

Was claim denied? Yes ☐ No ☐

[Attach additional sheets as necessary to describe more than one claim.]

G. Life Insurance: Within the last ten (10) years, have you ever been denied life insurance based on health reasons?

Yes ☐ No ☑

If yes, please state when, the name of the life insurance company, and the company's stated reason for denial (if any):

H. Other Lawsuits: Has Plaintiff ever been a party to a personal injury lawsuit, *other than* in the present suit?

Yes ☐ No ☑

If yes, state: (1) nature of the case (2) the state and county in which claim was filed, (3) the caption, case name and/or names of adverse parties, (4) the civil action or docket number assigned to each such claim, action or suit, (5) attorney who represented you, (6) a description of the nature of your claim, (6) the current status of the claim, and (7) amount of damages or compensation received (unless subject to protective order or confidentiality agreement).

Nature of the Case	State and County in which claim was filed	Caption, Case Name and/or names of adverse parties	Civil Action or Docket Number	Attorney who represented you	Description of the Nature of the claim and Current Status	Amount of damages or compensation received

I. Convictions: Have you ever been convicted of, or pled guilty (or no contest) to, a felony and/or a crime involving fraud or dishonesty?

Yes ☐ No ☑

If yes, please provide the following information for each such conviction/guilty plea: (l) the crime or offense, (2) the state and county in which you were convicted or pled guilty or no contest, (3) the date on which you were convicted or pled guilty or no contest, and (4) the sentence or other outcome.

Crime or Offense	State and County Where Proceedings Took Place	Date of conviction, guilty or no contest plea	Sentence or other outcome

J. Computer Use: Have you had access to a computer at any time during the past five (5)years?

Yes ☑ No ☐

If yes, then answer the following:

1. Did you visit within the past five years any website containing information regarding Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) contamination with NDMA or other carcinogenic substances?

   Yes ☐ No ☑ Do Not Recall ☐

   If yes, identify the websites and the dates viewed:

2. Did you communicate in the past ten (10) years via email, visit any chat rooms, or publicly post a comment, message or blog entry on a public internet site regarding your health, Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)? (You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" where the general public may post such comments).

   Yes ☐ No ☑ Do Not Recall ☐

   If yes, please tell us where and when you made such public posts and the substance of what was posted.

K. Bankruptcy: Have you or your spouse ever filed for bankruptcy?

Yes ☐ No ☑

If yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the date of the orders of discharge, if any:

Date Bankruptcy Filed	Court in Which Bankruptcy was Filed	Docket Number	Discharge Date (if applicable)

III. CLAIM INFORMATION

A. Hypertension

1. Relevant History

a. When were you first diagnosed with hypertension?

March 2016

b. If you discontinued the Valsartan products, how have you managed or treated your hypertension?

Change to Amlodipine - 5 mg tabs

B. Valsartan

1. Are you currently taking Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/ Hydrochlorothiazide (HCTZ)?

Yes ☑ No ☐

2. Have you ever received any samples of Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑ Do Not Recall ☐

If yes, please state the following: (1) who gave you the sample(s); (2) when the sample(s) were provided; and (3) how many sample(s) you received:

Physician/Clinic/individual who provided samples	When Samples Were Provided	How Many Samples You Received

Physician/Clinic/individual who provided samples	When Samples Were Provided	How Many Samples You Received

3. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ)?

Yes ☑ No ☐ Do Not Recall ☐

If yes, please describe the documents if you no longer have them. If you have the documents, please produce them or make them available for inspection.

documents given when prescription was filled

4. Were you given any oral instructions regarding your use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑ Do Not Recall ☐

If yes, please identify each person who gave you oral instructions about Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) and describe what he or she told you:

5. Do you have in your possession, or does your attorney have, the container or packaging from the Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) you allege to have used?

Yes ☐ No ☑

If yes, who currently has custody of the Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) container or packaging?

6. Have you ever seen any advertisements *(e.g.,* in magazines or television commercials) for Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑ Do Not Recall ☐

If yes, identify the advertisement or commercial, state the nature and content of each advertisement or commercial, and approximately when you saw the advertisement or commercial:

7. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives regarding the Valsartan recall?

Yes ☐ No ☑ Do Not Recall ☐

If yes, please identify:

Date of Communication: _____

Method of Communication:

_____

Name of Defendant/representative:

_____

Substance of communication between you and any representative(s) of the Defendants:

C. For each non-cancer physical injury claimed, please provide the following information:

1. Describe the nature of physical your injury, illness, or disability:

2. When did this/these physical injury(ies) first occur?

a. Have you ever been hospitalized as a result of any of this/these physical injury(ies)?

If yes, please provide the following information:

i. Approximate date(s) of hospital admission:

ii. Approximate date(s) of discharge:

iii. Hospital name(s) and address(es):

Non-Cancer Physical Injury, Illness, or Disability	When did this/these first occur	Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital Name(s) and Address(es)

Non-Cancer Physical Injury, Illness, or Disability	When did this/these first occur	Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital Name(s) and Address(es)

Non-Cancer Physical Injury, Illness, or Disability	When did this/these first occur	Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital Name(s) and Address(es)

3. Procedures and/or Treatments.

a. Identify the primary treating physician(s) for the physical injuries you claim in this case:

Medications Prescribed
Did you receive any treatment other than medication?

Primary Treating Physician(s)	Medication Prescribed	Did you receive any treatment other than medication?

Primary Treating Physician(s)	Medication Prescribed	Did you receive any treatment other than medication?

b. Please list all major hospitalizations, surgeries, and/or procedures you have undergone in the last 10 years?

Treatment/Procedure	Reason for Treatment/Procedure	Date of Treatment/ Procedure
Colon Resection	Colon Cancer	Aug 16 2019

Treatment/Procedure	Reason for Treatment/Procedure	Date of Treatment/ Procedure

c. For each treatment and/or procedure for which you answered Yes in the previous chart, please provide the information requested below:

Name of health care provider(s)	Address and Phone Number
Daniella Prodanovic, MD	Beth Israel Deaconess Hospital Plymouth MA 02360 Tel.: 508-747-1560
Jill Allen, MD	Massachusetts General Hospital 55 Fruit St, #148, Boston MA 02114 Tel.: 617-726-2000
Dimitar Dimitrov, MD	286 Kingstown Way Duxbury MA 02332 Tel.: 781-582-1402
Hiroko Kunitake, MD	Mass General Hospital 55 Fruit St. Boston MA 02114 Tel.: 617-726-2066
Daniel Oates, MD	286 Kingstown Way Duxbury MA 02332 Tel.: 617-505-1036
	Tel.:
	Tel.:
	Tel.:

Name of health care provider(s)	Address and Phone Number
	Tel.:
	Tel.:
	Tel.:
	Tel.:
	Tel.:
	Tel.:
	Tel.:
	Tel.:

4. Were you treated by any healthcare provider or at any hospital for this/these injury(ies) who is not identified in the Core Case Information section above?

Yes ☐ No ☑

If yes, please provide the following information:

Name of health care provider and Hospital	Address and Phone Number	Approx. date(s) of treatment
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present

5. At the time you were diagnosed with the injury(ies) you attribute to your use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), were you undergoing treatment that lasted for a minimum of 6 months for any other medical conditions? If so, describe each other medical condition, and the treatment.

Medical Condition	Treatment

6. At the time you were diagnosed with the injury(ies) you attribute to your use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) what other prescription and over the counter medications were you taking, that you took for a minimum of 6 months?

D. Does any injury, illness, or disability you attribute to the Valsartan Products persist today? Yes ☑ No ☐

If yes, identify the current symptoms, the medication or treatment you continue to receive, the health care provider(s) providing treatment, and that health care provider's address:

Current Symptoms	Medication or Treatment you continue to receive	Health care provider(s) providing treatment	Health care provider's address
Minimal	Monitoring - testing every three (3) months	Mass General Hospital	100 Cambridge Street Boston MA

E. Emotional Injury: Are you claiming a diagnosed mental and/or emotional injury as a result of the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑

1. *If yes,* what diagnosed mental and/or emotional injury do you claim resulted from the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

2. *If yes,* for each healthcare provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for diagnosed psychological, psychiatric, or emotional injuries as a result of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), state the following:

Name	Address	Condition Treated	Date Treated	Medications Prescribed
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	

Name	Address	Condition Treated	Date Treated	Medications Prescribed
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	
			to ☐ Present	

F. Lost Wages: Do you claim that you lost wages or suffered impairment of earning capacity as a result of any condition you allege was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑

1. *If yes,* state the period or periods involved, and the total amount of time you have lost from work as a result of any condition you claim was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ).

Period or Periods	Total time lost from work

Period or Periods	Total time lost from work

2. If yes, state your annual gross income you derived from your employment for each of the five (5) years prior to the injury or condition you claim was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ).

Year	Annual gross income

Year	Annual gross income

3. If yes, state the annual gross income for every year following the injury or condition you claim was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan /Hydrochlorothiazide (HCTZ).

Year	Annual gross income

Year	Annual gross income

4. If yes, state the total amount of income you claim you lost as a result of any condition you claim was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ):

$ _____

G. Medical Expenses: Please list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Valsartan, Amlodipine/Valsartan,Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) for which you seek recovery in the action which you have filed.

Provider	Date			Expense
Massachusetts General Hospital	Aug	20	2019	$610.00
Massachusetts General Hospital	Aug	20	2019	$5,652.65
Massachusetts General Hospital	Sep	3	2019	$450.00

Provider	Date			Expense
Massachusetts General Hospital	Aug	28	2019	$345.00
Massachusetts General Hospital	Aug	30	2019	$438.00
Massachusetts General Hospital	Sep	23	2019	$2,774.00
Massachusetts General Hospital	Sep	23	2019	$6,280.00
Massachusetts General Hospital	Sep	23	2019	$57,362.19
Massachusetts General Hospital	Nov	22	2019	$840.00
Massachusetts General Hospital	Feb	1	2020	$2,577.00
Massachusetts General Hospital	Feb	4	2020	$748.00
Massachusetts General Hospital	Jun	4	2020	$286.00
Newton Wellesley Hospital	Jun	5	2020	$305.00

Provider	Date			Expense
Jill Allen, MD Mass General Hospital	??	??	2020	$1,500.00 (ongoing follow up)
Daniel Oates, MD Duxbury MA	Jan	??	2019	$2,500.00
Dimitar Dimitrous, MD Duxbury MA	Jan	??	2019	$500.00
Hiroko Kunitake, MD Mass General Hospital	Aug	??	2019	$57,362.19
Daniella Prodanovic, MD Beth Israel Deaconess Hospital Gastroenterology	??	??	2019	$2,000.00 (ongoing follow up)

Provider	Date	Expense

Provider	Date	Expense

Provider	Date	Expense

Provider	Date	Expense

Provider	Date	Expense

Have you had any discussions with any doctor or other healthcare provider about: (1) whether Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) caused or contributed to your injury;

Yes ☐ No ☐ Do Not Recall ☑

and/or (2) other causes of your injury? Yes ☐ No ☐ Do Not Recall ☑

If yes, please identify:
Name of health care provider
Address
Date of discussion
What were you told? (Describe discussion regarding Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan Hydrochlorothiazide (HCTZ) and/or other causes of your injury)

Name of health care provider	Address	Date of Discussion	What were you told?

Name of health care provider	Address	Date of Discussion	What were you told?

[If discussed with more than one doctor, please answer for each doctor, using additional pages as necessary.]

H. Is Plaintiff claiming any other unique or specialized economic damages (e.g., tuition for specialized education, alterations to home to accommodate disability) as a result of any condition you allege was caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCZT), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCZT)? If yes, please describe each:

IV. LIST OF HEALTHCARE PROVIDERS

A. Healthcare Providers (Excluding Mental Health Care Providers, unless you are claiming damages related to a diagnosed mental health condition): Identify each physician, doctor, or other health care provider, including providers of telemedical services, whether real-time telemedicine, remote patient monitoring, or store-and-forward service, who has provided treatment to you for hypertension or cancer, or primary care, or who you use as a primary care provider (for non-primary care specialists used as a primary care provider, so indicate in the table below) in the past ten (10) years and the reason for consulting the health care provider, to the extent not set forth above regarding treatment of hypertension or mental health care (attach additional sheets as necessary).

Name and Medical Specialization	Address and Phone Number	Approximate Dates	Reason for Consultation	Check if a Current Healthcare Provider
Dimitar Dimitrov, MD Primary Care	286 Kingstown Way Duxbury MA 02332 Tel.: 781-582-1402	?? 2016 to ?? 2019 ☐ Present	Annual Physical & Hypertension	☐
Daniel Oates, MD	286 Kingstown Way Duxbury MA 02332 Tel.: 781-582-1402	?? 2019 to ☑ Present	Annual Physical & Hypertension	☑
Hiroko Kunitake, MD	Mass General Hosptial 55 Fruit St, Boston MA Tel.:	Aug 2019 to ☐ Present	colon cancer surgery	☐
Jill Allen, MD	Mass General Hosptial 55 Fruit St. Boston MA Tel.:	Oct 2019 to ☑ Present	Oncology, post surgery monitoring	☑
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐

Name and Medical Specialization	Address and Phone Number	Approximate Dates	Reason for Consultation	Check if a Current Healthcare Provider
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐

Name and Medical Specialization	Address and Phone Number	Approximate Dates	Reason for Consultation	Check if a Current Healthcare Provider
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐
	Tel.:	to ☐Present		☐

Name and Medical Specialization	Address and Phone Number	Approximate Dates	Reason for Consultation	Check if a Current Healthcare Provider
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐
	Tel.:	to ☐ Present		☐

Name	Address and Phone Numbers	Approximate Dates	Reason for Treatment
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	

Name	Address and Phone Numbers	Approximate Dates	Reason for Treatment
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	
	Tel.:	to ☐ Present	

C. Pharmacies: Identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from which you have received any prescription medication in the past ten (10) years (attach additional sheets as necessary):

Name of Pharmacy	Address and Phone Number of Pharmacy	Approximate Dates
Stop & Shop Pharmacy	160 Summer Street Kingston MA 02364 Tel.: 781-582-3703	Mar 2016 to ☑ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present
	Tel.:	to ☐ Present

D. Insurance Carriers: Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years, and the policy number (attach additional sheets as necessary).

Carrier	Policy Number	Approximate Dates of Coverage
Medicare	5DW8-129-YM45	?? ?? 2015 to ☑ Present
Tufts Supplemental	S0092834	?? ?? 2015 to ☑ Present
Humana Premier RX Plan	H45694985	?? ?? 2016 to ☑ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present
		to ☐ Present

E. Other Witnesses: Other than those previously identified, please identify all persons who you believe possess information concerning your injury and/or your current medical condition. For each person, please state their name, address, phone number, relationship to you, and the information you believe they possess (attach additional sheets as necessary).

Name	Address and Phone Number	Relationship	Information you believe they possess
Kevin Lalonde	43 Oak Street Duxbury MA 02332 Tel.: 781-588-5182	Husband	Observed me filling prescriptions, taking medications, medical visits and procedures
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

V. MEDICAL BACKGROUND

A. Height and weight at the time your first alleged Valsartan-related cancer was diagnosed:

Height: 5'4" Weight: 168

B. Height and weight at the time your alleged Valsartan-related cancer was in remission (if applicable):

Height: 5'4" Weight: 150

C. Current Weight: 162

D. Tobacco Use History:

Did you use tobacco, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff at any time?

Yes ☐ No ☑

If you answered *yes*, please identify the types of tobacco used and the amount used.

Types of tobacco used: cigarettes ☐ cigars ☐ vaping ☐
pipes ☐ chewing tobacco/snuff ☐

Date tobacco use started: _____

Date tobacco use ceased: _____

Amount used: on average, _____ per day for _____ years

E. Alcohol Use History

Do you currently or have you in the past drank alcohol (beer, wine, whiskey, etc.)?

*If yes, p*lease check which of the following represents your typical alcohol consumption in the ten (10) years leading up the date on which you first experienced any symptoms you believe are related to your alleged injury(ies):

☐ 1-2 drinks per week
☐ 3-6 drinks per week
☐ 7-10 drinks per week
☐ 10 or more drinks per week
☑ Other - explain: Less than one drink per week

Type of Alcohol Consumed:

Wine

F. Have you been diagnosed with, or treated for any of the following in the past ten (10) years? If so, for each condition for which you answer yes, please provide the additional information requested below:

Condition	Yes	No	Unknown
Cancer of any type prior to Valsartan use /other than the cancers alleged above (Including, but not limited to, lung, colon, liver, breast, kidney, skin, stomach, testicular, leukemia, Hodgkin's disease, or Non-Hodgkin's lymphoma)	☐	☑	☐
Celiac Disease	☐	☑	☐
Cirrhosis	☐	☑	☐
Colon polyps	☐	☑	☐
Common variable immunodeficiency (CVID)	☐	☑	☐
Persistent Constipation	☐	☑	☐
Diagnosed and Treated Depression/ Anxiety	☐	☑	☐
Diabetes	☐	☐	☐
Persistent Diarrhea	☐	☑	☐
Epstein-Barr virus	☐	☑	☐
Gallbladder disease	☐	☑	☐
Gastrointestinal bleeding	☐	☑	☐
Genetic condition(s) (list all)	☐	☑	☐
Gluten sensitivity or intolerance	☐	☑	☐
Hepatic dysfunction or active liver disease	☐	☑	☐
Hemochromatosis	☐	☑	☐
Hepatitis B virus	☐	☑	☐
Hepatitis C virus	☐	☑	☐
Human immunodeficiency virus (HIV)	☐	☑	☐
Human papillomavirus	☐	☑	☐
Hyperlipidemia	☐	☑	☐

Condition	Yes	No	Unknown
Hypertension (High Blood Pressure)	☑	☐	☐
Hypotension (Low Blood Pressure)	☐	☑	☐
Intestinal obstruction	☐	☑	☐
Increased C-Reactive Protein (CRP) levels	☐	☑	☐
Infectious disease: typhoid fever, encephalitis, H. pylori	☐	☑	☐
Inflammatory Bowel Disease	☐	☑	☐
Irritable Bowel Syndrome	☐	☑	☐
Jaundice	☐	☑	☐
Kidney Problems (disease, infections, stones, protein in urine, etc.)	☐	☑	☐
Liver dysfunction	☐	☑	☐
Liver tumor	☐	☑	☐
Malabsorption	☐	☑	☐
Persistent Nausea	☐	☑	☐
Non-cancerous tumors	☐	☑	☐
Diagnosed Obesity	☐	☑	☐
Pancreatic cysts	☐	☑	☐
Pancreatic insufficiency	☐	☑	☐
Pulmonary Embolism /blood clot in lung	☐	☑	☐
Refractory celiac disease	☐	☑	☐
Renal Insufficiency	☐	☑	☐
Retinal bleed	☐	☑	☐
Stomach ulcers/Peptic ulcers (requiring surgery)	☐	☑	☐

Condition	Yes	No	Unknown
Stomach polyps	☐	☑	☐
Stroke of any type (hemorrhagic, ischemic, etc.)	☐	☑	☐
Transient Ischemic Attack (TIA)	☐	☑	☐
Ulcerative Colitis	☐	☑	☐
Sudden, substantial weight loss	☐	☑	☐
Persistent Vomiting	☐	☑	☐

G. For each condition for which you answered yes in the previous chart, please provide the information requested below (attach additional sheets as necessary).

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
hYPERTENSION	Daniel Oates, MD 286 Kingstown Way Duxbury MA 02332 Tel.: 781-582-1402	Mar 17 2016	Losarton and other medications which developed colon cancer
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

Condition	Name, Address, and Phone Number of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		
	Tel.:		

VI. MEDICATIONS

A. In the ten (10) years prior to when you first took Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), list the following for any additional prescription medications you took on a regular basis (more than three (3) consecutive months):

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
None		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/ years taken	Dosage and frequency of use	Reason for prescription	Name and address of pharmacy
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

B. For the three (3) year period before the onset of the injuries for which recovery is sought in this action, set forth: (a) the name of each and every over the counter or non-prescription drug product that you regularly or consistently took (including all vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies); (b) the prescribing/recommending physician (if any); (c) the approximate dates/years taken; (d) the dosage ingested and frequency of use; (e) the purpose for using each such product; and (f) the pharmacy or store where the product was purchased.

Name of Over the Counter or Non-Prescription Drug Product	Healthcare provider(s) that prescribed/ recommended the product	Approximate dates/years taken	Dosage and frequency of use	Reason for use	Pharmacy/ Store where purchased
None		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Over the Counter or Non-Prescription Drug Product	Healthcare provider(s) that prescribed/ recommended the product	Approximate dates/years taken	Dosage and frequency of use	Reason for use	Pharmacy/ Store where purchased
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Over the Counter or Non-Prescription Drug Product	Healthcare provider(s) that prescribed/ recommended the product	Approximate dates/years taken	Dosage and frequency of use	Reason for use	Pharmacy/ Store where purchased
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

Name of Over the Counter or Non-Prescription Drug Product	Healthcare provider(s) that prescribed/ recommended the product	Approximate dates/years taken	Dosage and frequency of use	Reason for use	Pharmacy/ Store where purchased
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			
		to ☐ Present			

VII. CANCER DIAGNOSIS AND TREATMENT

A. Cancer Diagnosis & Treatment Generally

1. Have you ever been diagnosed with cancer? Yes ☑ No ☐

   Were you diagnosed with cancer more than once? Yes ☐ No ☑

   Did you undergo any of the following for cancer?

Treatment	Treated
Surgery	☑
Radiation	☐
Chemotherapy	☐

For surgery, specify:

Type of Surgery	Date of Surgery
Colon Resection	Sep 23 2019

2. Please state the following for EACH cancer diagnosis you may have that you do not claim resulted from your use of Valsartan:

Type of Cancer	None
Date of Diagnosis	
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Primary Oncologist	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:
Treatment Facility	Name: Address: Street City State Zip Code Dates of Treatment: to ☐ Present Treatment:

VIII. FAMILY MEDICAL HISTORY

Please indicate, to the best of your knowledge, whether your children, parents, siblings, or grandparents have ever had any cancer diagnosis or treatment:

Family Member	Family Member's Relationship to You	Cancer Type and Primary Location	Age at Diagnosis	Date of Diagnosis	Treatment and Outcome
None					

IX. FRAUD CLAIMS

1. Are you claiming fraud or consumer fraud in this action on the basis of Plaintiff-specific allegations other than those set forth in the Master and Short Form Complaints?

   Yes ☐ No ☑

   If yes, please answer the following questions:

2. What representation(s) do you claim was falsely or fraudulently made and to whom was it made?

3. By whom?

4. How was it made?

5. When was the alleged representation(s) made? Identify approximate date(s).

6. Were these representations in writing? Yes ☐ No ☐

7. If the representations were in writing, did you retain and currently have the original or a copy of those representations? Yes ☐ No ☐

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

A. Are you completing this Fact Sheet on behalf of an individual who is deceased?

Yes ☐ No ☑

If yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration.

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____

Place of death:

_____

Facility or location where death occurred:

_____

Name of physician who signed death certificate:

_____

Cause of death:

_____

B. Are you completing this fact sheet on behalf of an individual who is deceased and on whom an autopsy was performed?

Yes ☐ No ☑

If yes, please attach a copy of the autopsy report.

C. Are you claiming wrongful death as a result of the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☑

XI. DOCUMENT DEMANDS

A. AUTHORIZATIONS [To be served within twenty (20) days after service of the Plaintiff Fact Sheet ("PFS")]

1. Health Care Authorizations - For each primary health care provider, specialist used as a primary health care provider, and each health care provider who diagnosed or treated the injuries attributed to the Valsartan product, identified in the PFS, please provide a completed and signed (but undated) Health Care Authorization in the form attached as **Exhibit "A."**

2. Tax Return 4506 and 4506-T IRS Forms

   a) Only if you answered "Yes" to question III.F and are asserting a claim for lost wages or a reduction in earning capacity, please provide a completed and signed IRS Form 4506 and 4506-T attached as **Exhibit "B"** for each year identified in your answer to question III.F, and for the immediately preceding five (5) calendar years.

   b) If you answered "No" to question III.F in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506 or 4506-T.

3. Authorizations for the Release of Employment Records

   a) Only if you answered "Yes" to question III.F and you are asserting a claim for lost wages or a reduction in or loss of earning capacity, please provide a completed and signed (but undated) Employment Authorization in the form attached as **Exhibit "C."**

   b) If you answered "No" to question III.F in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide an Employment Authorization.

4. Authorization for Release of Workers' Compensation Records

   Only if you answered "Yes" to question II.F in the PFS and have previously applied for Worker's Compensation related to a claim of occupational exposure to a carcinogenic substance, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each government agency or employer company you submitted your application to in the last ten (10) years in the form attached as **Exhibit "D."**

   a) If you answered "No" to question II.F in the PFS you are not required to provide Release of Workers' Compensation Records.

5. Authorization for Release of Disability Records

   Only if you answered "Yes" to question II.F in the PFS and have previously applied for Disability benefits, please provide a completed and signed (but undated) Authorization for Release for each government agency or company you submitted your application to in the last ten (10) years in the form attached as **Exhibit** "E."

   a) If you answered "No" to question II.F in the PFS you are not required to provide Release of Disability Records.

6. Insurance Records Authorization - For each company listed in your response to question IV.D in this Fact Sheet, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "F."**

7. Authorizations for Release of Records of treatment of behavioral or mental health conditions.

   a) Only if you answered "Yes" to question III.E. and are asserting a claim for a diagnosed emotional or mental injury, please provide a completed and signed (but undated) Health Care Authorization in the form attached as Exhibit **"G."**

   b) If you answered "No" to question III.E. in the PFS and are not asserting an Emotional Injury claim, you are not required to provide Release of Mental Health Care Authorization.

B. OTHER RELEVANT DOCUMENTS DEMANDS

Requests for documents in your possession or the possession of your lawyers, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession or the possession of your lawyers). Please indicate by answering "Yes" or "No" which documents you have, and attach a copy of each of those you have to this Plaintiff Fact Sheet with your responses to the questions above:

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet.

   Responsive Documents Attached ☑

   I have no documents responsive to this request ☐

2. A copy of all medical and pharmacy records in your possession relating to the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), and relating to the treatment of any condition you claim is related to the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), from any hospital or health care provider who treated you in the past fifteen (15) years, including, but not limited to, all imaging studies of any part of your body, and laboratory, test results, pathology reports, and biopsy reports, that relate in any manner to the diagnosis, treatment, care, or management of your condition and the injuries alleged in your complaint.

   Responsive Documents Attached ☑

   I have no documents responsive to this request ☐

3. All x-rays, CT scans, MRIs or other radiographic images of any part of your body.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

4. All laboratory, pathology and biopsy reports and results of same.

Responsive Documents Attached ☑

I have no documents responsive to this request ☐

5. All documents, including but not limited to, personal or professional letters, diaries, calendars, journals, logs, date books, video or audio tapes or other documents, materials or things of Plaintiff's or any member of Plaintiff's family, relating to or reflecting your use of any prescription drug or medication in the past ten (10) years.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

6. All product use instructions, product warnings, package inserts, medication guides, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide(HCTZ), and/or Amlodipine/ Valsartan/Hydrochlorothiazide (HCTZ).

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

7. If you have been the claimant or subject of any workers' compensation, social security, or other disability proceeding related to your ingestion of any Valsartan products, all documents relating to such a proceeding.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

8. Copies of: advertisements or promotions for Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ), which you saw before or while you were using Valsartan, and articles discussing Valsartan, Amlodipine/Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), which you read before or while you were using Valsartan, including but not limited to, legal advertisements related to the recall or this litigation.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

9. Copies (or photos were applicable) of the packaging, including the container/packaging and label for Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/ Hydrochlorothiazide (HCTZ) (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).
Responsive Documents Attached ☐
I have no documents responsive to this request ☑

10. All documents relating to your purchase of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ) including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase.
Responsive Documents Attached ☑
I have no documents responsive to this request ☐

11. All documents known to you and in your possession which mention Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/Hydrochlorothiazide (HCTZ), or any alleged health risks or hazards related to Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance.
Responsive Documents Attached ☐
I have no documents responsive to this request ☑

12. All documents in your possession or in the possession of anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants regarding the valsartan recall.
Responsive Documents Attached ☐
I have no documents responsive to this request ☑

13. All documents constituting any communications or correspondence between you and any representative of the Defendants regarding the valsartan recall.
Responsive Documents Attached ☐
I have no documents responsive to this request ☑

14. All photographs, drawings, journals, slides, videos, DVDs or any other media, including any "day in the life" videos, photographs, recordings, or other media that you may utilize to demonstrate damages relating to your alleged injury.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

15. Any and all documentation of Plaintiff's use of social media, Internet postings, or other electronic networking website (including, but not limited to, Facebook, MySpace, Linkedin, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards) relating to the recall of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), or any of your claims in this lawsuit.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

16. Copies of all documents you (and not your lawyer) obtained from any source relating to the contamination or recall of Valsartan, Amlodipine/Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), including but not limited to legal advertising materials relating to the recall or this litigation.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

17. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), and every year thereafter or W-2s for each of the five (5) years preceding the injury you allege to be caused by Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/ or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), and every year thereafter.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

18. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

19. Copies of all records of any other expenses allegedly incurred as a result of the injuries alleged in the complaint.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

20. All public statements made by or on behalf of you relating to this litigation in your possession.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

21. Copies of letters testamentary or letters of administration relating to your status as a representative of a living or deceased plaintiff (if applicable).

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

22. Decedent's death certificate and autopsy report (if applicable).

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

23. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first use of Valsartan Products.

Responsive Documents Attached ☐

I have no documents responsive to this request ☑

XII. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part XI of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied/will supply all applicable Authorizations attached to this declaration, in accordance with the terms of this Plaintiff Fact Sheet.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Nancy E. LaLonde — 02/04/2021

Plaintiff's Name (Signature) — Date

NANCY E. LALONDE

Plaintiff's Name (Printed)